JCAHO *Accredited*

Home Rehabilitation Healthcare Agency Inc.
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DOCTOR'S ORDER

DR. ____________________ DATE: ____________________

ADDRESS____________________ PATIENT'S NAME ____________________

____________________ SOC______________ MR#________

PHONE # ____________________ DIAGNOSIS_GAIT ABNORMALITY____

PROBLEMS	GOALS/TIME FRAME 6WKS
☐ IMPAIRED BED MOBILITY______	☐ IMPROVE BED MOBILITY TO______
☒ IMPAIRED TRANSFER ______	☐ IMPROVE TRANSFER TO______
☒ IMPAIRED AMBULATION______	☐ IMPROVE AMBULATION TO______
☐ DECREASED ROM ______	☐ INCREASE ROM TO______
☒ IMPAIRED MSCL STRENGTH ______	☐ INCREASE MSCL STRENGTH TO______
☒ IMPAIRED BALANCE ______	☒ INCREASE BALANCE TO ______
☐ IMPAIRED COORDINATION ______	☐ IMPROVE COORDINATION TO ______
☐ PAIN _______ON SCALE OF 0-10 ______	☐ DECREASE PAIN TO______ON SCALE OF 0-10 ______
☒ NO HOME EXERCISE PROGRAM ______	☒ ESTABLISH HOME PROGRAM ______
☐______	☒______
☐______	☐______

☒ Evaluation______	☐ Level ______ ☐Stair ______	☐Other
☒ Therapeutic Exercise______	☐Curb ______ ☐ Ramp______	☐ Safety Training
☐ Passive ☐ Active Assisted	☐Assistance-Devices ______	☐Equipment training
☐ Active ☐Resistive ☐Balance	☐ Stand by Assistance______	☐ADL Training
☐Coordination ☐ Instruct In HEP	☐ Max ☐ Mod ☐Min	☐Chest/Breathing Therapy
☒Transfer Training ______	☐ Contact Guard	☐Ortho Precautions
☐ Bed/Chair/Toilet ☐Shower/tub	☐ Verbal Cueing	☐ Edema Reduction
☐Bed Mobility ☐W/C ☐ Auto	☐ Independent	☐ Body Mechanics
☐ Floor	☐ Pulmonary P.T. ______	☐Energy Conservation/Endurance
☒Home Program ______	☐ Ultrasound______	☐Tone Reduction
☒ Gait Training ______	☐ Electrotherapy ______	☐Prosthetic training
☐WB Status ______	☐Prosthetic Training______	
	☐Fabrication Temporary Devices	
	☐Muscle Re-Education	

FREQUENCY/DURATION:____________________

THANK YOU FOR YOUR TRUST AND SUPPORT

____________________ ____________________

SN/PT SIGNATURE/DATE PHYSICIAN SIGNATURE/DATE